Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON HOSPITAL FOR SPECIALIZED SURGERY
5445 LA BRANCH STREET
HOUSTON TX 77004

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1887-01

MFDR Date Received
FEBRUARY 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied for no authorization on 10/25/2011. The authorization was sent over from the doctor's office with the patient and was on the claim when it was filed the claim was appealed with the authorization the medical records and denied for no authorization on 12/30/2011."

Amount in Dispute: $5,713.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided outpatient surgical services on 8/31/11 related to continued bleeding from the claimant's left hand…Both the surgeon and the requestor billed this with CPT codes 32507 and 69990. The codes descriptor for 32507 from the 2011 CPT is 'Repair of blood vessel, direct: hand, finger.' The requestor argues it received preauthorization for the 8/31/11 procedure under authorization number 9168440. Yet, this authorization was for evacuation of a hematoma from and debridement of the surgical wound of the left hand. The code for this procedure provided by the surgeon was 10140…The authorization for the actual procedure performed on 8/31/11, i.e. repair of the blood vessel, was under number 9775767…The date range authorized under 9175767 was 9/2/11 through 10/3/11. Neither the surgeon nor the requestor had authorization to perform the blood vessel repair on 8/31/11. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2011	Outpatient Services	$5,713.32	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific

treatments and services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-B5-Coverage/program guidelines were not met or were exceeded.
   - CAC-198-Precertification/authorization exceeded.
   - 728-This bill was reviewed /denied in accordance with your First Health Contract.
   - 759-Service not included in and/or exceeds preauthorization approval.
   - CAC-193-Orignal payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724-No additional payment after a reconsideration of services.

Issues

1. Does a preauthorization issue exist in this dispute?

Findings

1. The insurance carrier denied reimbursement for the outpatient services, based upon "CAC-198-Precertification/authorization exceeded," and "759-Service not included in and/or exceeds preauthorization approval."

   28 Texas Administrative Code §134.600 (c)(1)((B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   The requestor states in the position summary that "The authorization was sent over from the doctor's office with the patient and was on the claim when it was filed."

   The respondent states in the position summary that "Neither the surgeon nor the requestor had authorization to perform the blood vessel repair on 8/31/11."

   In support of their position, the respondent submitted the following copies of preauthorization reports:
   - Report dated August 22, 2011 preauthorizing "O/P Left Palm Evacuate Hematoma from Surgical Wound Debridement 10140, with a start date of August 22, 2011 and end date of September 22, 2011.
   - Report dated September 2, 2011 preauthorizing "RUSH OP Left Hand Control of Severe Bleeding or Surgical Wound Debridement" with a start date of September 2, 2011 and end date of October 3, 2011.

   A review of the submitted medical bill indicates the OR Services were for CPT code 35207 and 69990.

   CPT code 35207 is defined as "Repair blood vessel, direct; hand, finger."

   CPT code 69990 is defined as "Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)."

   The requestor did not support position that preauthorization was obtained for the disputed service; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		1/29/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.